

NOTICE OF INDEPENDENT REVIEW DECISION

March 3, 2003

RE: MDR Tracking #: M2-02-1007-01
 IRO Certificate #: IRO 4326

The ____ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ____ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

____ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a ____ physician reviewer who is board certified in orthopedic surgery which is the same specialty as the treating physician. The ____ physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to ____ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This 43 year old male sustained a work-related injury on ____ when he developed aching along the medical border of his scapula on the right side while driving his delivery vehicle. Radiographs of the cervical spine revealed narrowed C5-6 and C6-7 disc spaces. An MRI of the cervical spine performed on 04/15/02 revealed severe multilevel degenerative joint disease of the cervical spine with moderate to severe canal stenosis at C4-5, C5-6, and C6-7 with cord flattening noted at C4-5, C5-6 and C6-7. The treating physician has recommended that the patient undergo a C4-7 anterior cervical discectomy and fusion.

Requested Service(s)

C4-7 anterior cervical discectomy and fusion

Decision

It is determined that the C4-7 anterior cervical discectomy and fusion is medically necessary to treat this patient's condition.

Rationale/Basis for Decision

There is documentation that the patient has had persistent symptoms for 11 months. There are notations of substantial loss of strength in the right upper extremity and MRI findings of moderate to severe canal stenosis at C4-5, C5-6, and C6-7 with cord flattening noted at C4-5, C5-6 and C6-7. Based on this medical record documentation, a discectomy with fusion at C4-7 is necessary for symptomatic relief and prevention of possible untoward neurological change. Therefore, the C4-7 anterior cervical discectomy and fusion is medically necessary.

This decision by the IRO is deemed to be a TWCC decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10** (10) days of your receipt of this decision (20 Tex. Admin. Code 142.5 (c)).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin Code 148.3).

This Decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin Code 102.4(h) or 102.5(d)). A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Workers' Compensation Commission, P.O. Box 40669, Austin, Texas, 78704-0012. **A copy of this decision should be attached to the request.**

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute (Commission Rule 133.308 (t)(2)).

Sincerely,

cc: Rosalinda Lopez, Program Administrator, Medical Review Division, TWCC

In accordance with Commission Rule 102.4 (h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 3 rd day of March 2003.
